

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

051110

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Margaret J. Bingnear

3. (b) Social Security Number

none

4. Sex.....

Female

5. Color or race.....

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

George Bingnear

7. Birth date of deceased (mo., day, yr.)

Oct 20 1896

6. (c) If alive, give age..... years

8. AGE:

30

Years

Months

Days

If less than one day

hrs

min.

9. Birthplace.....

Middletown Del.

10. Usual occupation.....

Housewife

11. Industry or business.....

William Bolton

12. Name.....

13. Birthplace.....

Del. City Del.

14. Maiden name.....

Amelia Barnes

15. Birthplace.....

Md.

16. Informant.....

George Bingnear

Address.....

Burlingame

17. (Burial, cremation, or removal, which?)

Burial

Date thereof.....

June 10, 1947

Cemetery or crematory.....

Grace Lawn Memorial

Location.....

Fannyhurst Del.

18. Funeral director.....

Edward Holloway

Address.....

Millington Md.

19. Date rec'd by registrar.....

June 9 1947

19. 47

Elizbeth J. Mulford

Full Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 7 1947, at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 7 1946, to June 7 1947

and that I last saw her alive on June 7, 1947

Immediate cause of death Epidermoid

Carcinoma grade T of hypopharynx

DURATION

9.00

Due to.....

Due to.....

Other conditions.....

Radiation sickness

(Include pregnancy within 3 months of death)

Major findings of operations.....

Biopsy

Date of op. 3/10/47

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Thodore F. Paprocki MD

M. D. or other

Address.....

Galeva, Md

Date signed 6-9-47

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JUN 12 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05111

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent
 City or town Chestertown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ---
 (If rural, give LOCATION)
 2.(a) If veteran, name war NO

3. (a) FULL NAME

Norman L. Black

3. (b) Social Security Number

2I7-09-396I

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced Common Law Wife

6.(b) Name of husband or wife Mamie Stewart

7. Birth date of deceased (mo., day, yr.) July 28, 1908
 6.(c) If alive, give age..... years

8. AGE: Years 38 Months 10 Days 13 If less than one day..... hrs. min.

9. Birthplace Kent Co. Maryland
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Earl Black13. Birthplace Kent Co. Maryland14. Maiden name Carrie Johnson15. Birthplace Kent Co. Maryland16. Informant Earl Black (Father)Address Chestertown, Md.

17. Burial Date thereof June 14 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broad Neck Cem.Location Chestertown, Md. (rural)18. Funeral director J. Willis WellsAddress Chestertown, Md.

19. June 13, 1947 Class S. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947 19..... at 2.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Did not attend Investigated death.

signed certificate as Deputy Med. Exam. Kent Co. Md.

Accident, Crushed Chest Wall

fracture all ribs left side

punctured lung Hemorrhage

Immediate

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 11, 1947

Where did injury occur? Chestertown R. Md.
 (City or town) (County) (State)

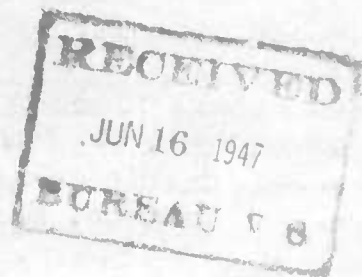
Injured at home, farm, industry, public place (where?) Farm

Means of injury Fell off Truck Injured at work? Yes

Deputy Med. Exam. Kent Co. Md.

23. SIGNATURE Paul Jones MD D or other

June 13/47 Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County KentCity or town Chester town
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 DAYS

Hospital, institution, or street address where death occurred:

Kent and Queen AnneHow long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Rural - Betterton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Rena E Bramble

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Elwood D. Bramble7. Birth date of deceased (mo., day, yr.) Nov 29 18898.(c) If alive, give age 61 years

8. AGE: Years Months Days It less than one day

57 7 _____ hrs. _____ min.9. Birthplace Betterton, Kent, Maryland
(Town, county, and state)10. Usual occupation Home wife

11. Industry or business

12. Name Thomas H. Moore13. Birthplace Maryland14. Maiden name Mary Wheeler15. Birthplace Maryland16. Informant Elwood D. BrambleAddress Betterton md17. Burial Still Pond Date thereof July 1 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Still Pond rdLocation Still Pond rd18. Funeral director B.R. FellowsAddress Still Pond rd19. June 30 1947 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947 at 6:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 22 1947 to June 28 1947and that I last saw him alive on June 28 1947Immediate cause of death Circulatory failureDURATION 7 daysDue to Fever of undetermined origin

Due to _____

Other conditions DiabetesPræmia

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A.C. Sick, M.D.Address Chester town, Md Date signed 6-28-47

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED

JUL 3 1947

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

05113

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH:

County KentCity or town near Chestertown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Chestertown, P.D. Ind
(If outside city or town limits, write RURAL and give nearest town)Street No. 1st St. Market Farm
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Thomas Clancy

3. (b) Social Security Number

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mary Elizabeth Shuman6.(c) If alive, give age 40 years7. Birth date of deceased (mo., day, year) September 16, 18888. AGE: Years 58 Months 58 Days 16 If less than one day
hrs. min.9. Birthplace Chestertown, Pa.
(Town, county, and state)10. Usual occupation Gen'l. Supplies Merchant11. Industry or business Chemist12. Name John T. Clancy13. Birthplace Conn.14. Maiden name Annie A. Clancy15. Birthplace Conn.16. Informant Mrs. John T. ClancyAddress Chestertown17. Burial Date thereof June 7, 1947

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or place of interment HarleighLocation Chestertown, P.D. Ind18. Funeral director Paul R. ReedAddress 1212 N. Charles St.19. John T. Clancy 19. 47 John T. Clancy

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 1947, at 6:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3, 1947 to June 3, 1947and that I last saw him alive on June 3, 1947

Immediate cause of death

Coronary thrombosisDue to Cardio VascularDue to Myocardial Infarction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank W. SmithAddress Chestertown Date signed June 4/47

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JUN 6 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *203*

05114

92d

1. PLACE OF DEATH:

County..... Kent
 City or town..... Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Kent
 City or town..... Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Gertrude Elizabeth Collyer

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... Samuel B. Collyer
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Mar. 10, 1870
 8. AGE: Years..... 77 Months..... 3 Days..... 17 If less than one day..... hrs. min.

9. Birthplace..... Talbot County Maryland
 (Town, county, and state)
 10. Usual occupation..... housewife
 11. Industry or business.....

FATHER
 12. Name..... Micheal Pinkind
 13. Birthplace..... Maryland
 MOTHER
 14. Maiden name..... Margaret Corkran
 15. Birthplace..... Maryland

16. Informant..... Melvin Collyer
 Address..... Rock Hall, Md.

17. Burial..... Date thereof..... June 29, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Wesley Chapel Cem
 Location..... Rock Hall, Maryland

18. Funeral director..... J. Willis Wells
 Address..... Chestertown, Md.

19. 6/28..... 19. 47 S. Elwood Byrnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 27 19 47 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 19 34 to June 27 19 47
 and that I last saw him alive on May 19 47

Immediate cause of death.....
Hypertension
shown in 1934 - Major crisis
 Due to..... Paralysis to side

Due to.....
 Other conditions.....

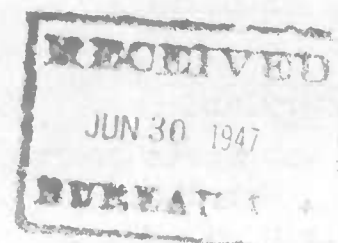
(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... Albert A. Burgard M.D.
 Address..... Rock Hall, Md. Date signed..... 6/28/47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05115

Reg. Dist. No. 302

1. PLACE OF DEATH:

County KentCity or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Kent & Queen Anne HospitalHow long in hospital or institution? 4 days

3. (a) FULL NAME

Josephine Cecelia Foreman

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Albert Foreman

7. Birth date of

deceased (mo., day, yr.)

7-3-18946. (c) If alive, give age 50 years

8. AGE:

Years

Months

Days

If less than one day

52""

hrs.

min.

9. Birthplace

Kent County, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Elewood Taylor

13. Birthplace

Kent County

MOTHER

14. Maiden name

Josephine Reiley

15. Birthplace

Kent County, Md.

16. Informant

Albert Foreman (husband)

Address

Chestertown, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6-18-1947

(month) (day) (year)

Cemetery or crematory

Silver Brook Cemetery

Location

Wilmington, Delaware

18. Funeral director

Address

J. Willis Wells19. June 16, 1947

Date rec'd by registrar

Registrar

Clara S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Kent

City or town

Chestertown, (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14 1947, at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1947, to June 14 1947and that I last saw h.e.r. alive on June 14 1947

Immediate cause of death

Bile peritonitis

DURATION

18 hrs

Due to

Ruptured duodenal ulcer18 hours

Due to

Other conditions

Common duct stone2 years

(Include pregnancy within 8 months of death)

Major findings of operations

Common duct stone; duodenalulcer

Autopsy results

Bile peritonitis; ruptured duodenal ulcer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

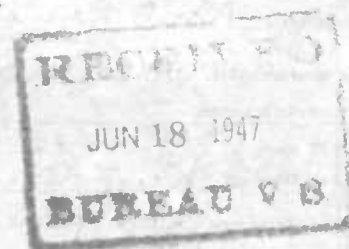
23. SIGNATURE

Address

Chestertown, Md.

M. D. or other

Date signed 6-14-47



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05116

202

1. PLACE OF DEATH:

County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Several
 Hospital, institution, or street address where death occurred:
High St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. High St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mary Jane Jarman

3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife G. Allen Jarman

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1863 6. (c) If alive, give age _____ years

8. AGE: Years 84 Months 5 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Delaware
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Francis S. McWhorter13. Birthplace Delaware14. Maiden name ? ? Bowen15. Birthplace Delaware16. Informant Mr. Gilbert A. JarmanAddress Baltimore, Md.

17. Burial Date thereof June 11, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chestertown CemeteryLocation Chestertown, Md.18. Funeral director J. Willis WellsAddress Chestertown, Md.

19. May 10, 1947 Class S. Barnes
 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9 1947 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 28 1947 to 6 9 1947
 and that I last saw him alive on 6-9 1947

Immediate cause of death Coronary artery
corditis DURATION 1

Due to Chronic rheumatoid
arthritis 7 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. G. Simpson M. D. or other

Ches. A. Barnes Address Date signed 6-10-47

J. Allen A.43

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JUN 12 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05117 2 18
Reg. Dist. No. 251

1. PLACE OF DEATH:

County Frederick Anne KentCity or town near Crumpton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Frederick Anne KentCity or town near Crumpton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Frances R. Lloyd

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

George R. Lloyd deceased

7. Birth date of deceased (mo., day, yr.)

Feb. 3 1870

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

7736

hrs.

min.

9. Birthplace

St. Marys Co. Ind.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Welfare Board

Address

Centerville Ind.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

June 14 1947
(month) (day) (year)

Cemetery or crematory

Crumpton

Location

Crumpton Ind.

18. Funeral director

Edgar L. Lane

Address

Church Hill Ind.

19.

June 12 1947
(Date rec'd by registrar)Edward H. Hefner
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 1947 to June 9 1947and that I last saw him alive on June 7 1947

Immediate cause of death

Coronary Heart Disease

Due to

Chronic Myocarditis

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work? _____

23. SIGNATURE

Ed Hefner

M. D. or other

Address

Frederick Ind.Date signed 6/10/47

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JUN 16 1947

BUREAU

[Faint handwritten notes at the bottom of the page]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 05118 203

1. PLACE OF DEATH:

County KentCity or town New Rock Hall
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life Time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town New Rock Hall
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Percival Clinton Smith

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced SingleB. (b) Name of husband or wife none7. Birth date of February 5th 1864 6. (c) If alive, give age _____ years

deceased (mo. day yr.)

8. AGE: Years 83 Months 4 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Pennsylvania

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name David A. Smith13. Birthplace Pennsylvania14. Maiden name Lucy Smith15. Birthplace Pennsylvania16. Informant David SmithAddress Rock Hall Md17. Burial Date thereof June 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Paul Cem.Location near-Fairlee (Kent Co.) Md.18. Funeral director J. Willis WellsAddress Chestertown, Md.19. June 11, 1947 S. Elwood Binger
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947 at 6:50 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept. 1944 to June 8, 1947and that I last saw him alive on June 8, 1947

Immediate cause of death

Coronary Occlusion DURATION 1 dayDue to Chronic Endocarditis 1944

Due to _____

Other conditions Hypertension 1944

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank W. Smith M. D. or other _____Address Chestertown Date signed June 9/47

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